

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10744

CERTIFICATE OF DEATH

10747

Reg. Dist. No. 100

Item 7. Film G190 12-7-55 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Chas.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>INDIAN Head</u>		<u>2 yrs</u>		TOWN <u>INDIAN Head (rural)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Robert</u> (Middle) <u>SAMUEL</u> (Last) <u>BARLOW</u>				(Month) <u>Nov</u> (Day) <u>25</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>W</u>	<u>Married</u>	<u>July 19 1875</u>	<u>80</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Carpenter</u>		<u>Cabinet maker</u>		<u>Va</u>		<u>U.S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Unk</u>				<u>Beth L. Down</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>223-05-2343</u>		<u>MRS GLADYS Whitlock</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
4222 IMMEDIATE CAUSE (A)				<u>Chronic Myocarditis</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>INDIAN Head</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				<u>2 yrs.</u>			
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<u>0</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>53</u> , to <u>11/25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/24</u> , 19 <u>55</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Frank H. Desan</u>				DATE SIGNED <u>11-25-55</u>			
ADDRESS <u>Indian Head Rd</u>							
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>#-28-10</u>		<u>11-28-55</u>		<u>Oakwood Cemetery</u>		<u>Richmond Va</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>11/28/55</u>		<u>Julia Harey</u>		<u>HUNT FUNERAL HOME, 172</u>		<u>WALDORF</u>	

CERTIFICATE OF DEATH

1915

DATE OF DEATH

PLACE OF DEATH

779

CHARLES

INDIAN HILL

INDIAN HILL

DATE OF DEATH

REPORT SUMMIT

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INDIAN HILL

INDIAN HILL

INDIAN HILL

INDIAN HILL

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BUREAU V. 2

NOV 30 1955

RECEIVED

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INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10745 CERTIFICATE OF DEATH

10748

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Charles</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Charles</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>Farmers</i>				TOWN <i>Farmers</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>George I.</i> (Middle) <i>BATEMAN</i> (Last)				(Month) <i>Nov.</i> (Day) <i>11</i> (Year) <i>1955</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>May 5 1875</i>	9. AGE last birthday <i>80</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>James</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME <i>Unk</i>				14. MOTHER'S MAIDEN NAME <i>Unk</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Norothy Bowie, Farmers Md</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <i>332X Left Hemiplegia</i>				INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<i>Hypostatic Pneumonia</i>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Nov 9, 1955</i> to <i>Nov 11, 1955</i> , that I last saw the deceased alive on <i>11/11/55</i> , and that death occurred at <i>10:30 PM</i> , from the causes and on the date stated above.							
SIGNATURE <i>William H. Kury</i> M.D.				ADDRESS (Street, city, town, state) <i>La Plata Md.</i> DATE SIGNED <i>11/12/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>11-14-55</i>		NAME OF CEMETERY OR CREMATORY <i>Mt Rest Cemetery</i>		LOCATION (City, town, or county) <i>La Plata, Md</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Julia H. Boney</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Hunt Funeral Home</i>		ADDRESS <i>Waldorf Md</i>	
DATE <i>11/14/55</i>							

10748

CERTIFICATE OF DEATH

[Faint, mostly illegible handwritten text on a form with multiple sections and lines.]

BUREAU V. S.
NOV 16 1955

RECEIVED

[Vertical text on the right margin, including "RECEIVED" and other administrative markings.]

1

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10749

10746 CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>La Plata</u>				TOWN <u>La Plata</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physicians Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Cooksey</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>11 - 22 19 55</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>	8. DATE OF BIRTH <u>11/22/55</u>		9. AGE last birthday yrs. <u>40</u>		IF UNDER 1 YEAR Months <u>40</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Floyd Allen Cooksey</u>				14. MOTHER'S MAIDEN NAME <u>Jane Catherine Redcliffe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>9</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mother</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						10. MEDICAL CERTIFICATION	
761.0 IMMEDIATE CAUSE (A) <u>MECHANICAL STRANGULATION, UMBILICAL</u>						INTERVAL BETWEEN ONSET AND DEATH <u>40 min.</u>	
ANTECEDENT CAUSE(S) DUE TO <u>CORD</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>PRECIPITATE BREECH DELIVERY</u>						<u>INSTANTANEOUS</u>	
(C) <u>HPNEA (DID NOT BREATHE AFTER BIRTH)</u>						<u>40 min.</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CARDIAC FAILURE</u>						<u>40 min.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/22</u> , 19 <u>55</u> , to <u>11/22</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/22</u> , 19 <u>55</u> , and that death occurred at <u>9:00</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>John H. Griffin</u> M.D.				ADDRESS (Street, city, town, state) <u>Hughesville Md.</u>		DATE SIGNED <u>11/22/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov 23, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Sacred Heart</u>		LOCATION (City, town, or county) (State) <u>La Plata Md</u>	
24. REC'D BY REGISTRAR DATE <u>11/22/55</u>		REGISTRAR'S SIGNATURE <u>Julia H. Boney</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harold A. Arnold Home</u>		ADDRESS <u>Wablog, Md</u>	

CERTIFICATE OF DEATH

Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible.

BUREAU V. S.

NOV 28 1955

RECEIVED

Handwritten notes at the bottom of the page, including "11/30/55" and "Fairly good" (partially obscured).

UNRECORDED

INSTRUCTIONS

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10747 **CERTIFICATE OF DEATH**

10750

Reg. Dist. No. 100

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>CHARLES</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Charles</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>LAPLATA</u>		TOWN <u>Waldorf</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>66 PHYSICIANS MEMORIAL HOSP</u>		<u>1</u>	
3. NAME OF DECEASED (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<u>MADE</u>		<u>NOV 16 1955</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>Female</u>	<u>Colored</u>	<u>SINGLE</u>	<u>31 OCT 1920</u>
9. AGE last birthday	IF UNDER 1 YEAR (Months) (Days)	IF UNDER 24 HRS. (Hours) (Min.)	
<u>35</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<u>DOMESTIC</u>		<u>Md.</u>	<u>U.S.</u>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>Stanley Dade</u>		<u>Nettie ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS	
		<u>Geo. Stewart, Waldorf Md.</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A)		INTERVAL BETWEEN ONSET AND DEATH	
<u>672x HEART FAILURE</u>		<u>15 minutes</u>	
ANTECEDENT CAUSE(S) DUE TO (B)		<u>30 minutes</u>	
<u>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</u>		<u>5 years</u>	
STATING UNDERLYING CAUSE LAST. DUE TO (C)			
<u>027x SYPHILIS</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
<u>0</u>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Nov 16</u>, 19<u>55</u>, to <u>16 Nov</u>, 19<u>55</u>, that I last saw the deceased alive on <u>16 Nov</u>, 19<u>55</u>, and that death occurred at <u>10:25</u> A.M., from the causes and on the date stated above.			
SIGNATURE		ADDRESS (Street, city, town, state)	DATE SIGNED
<u>J. Wooddy, M.D.</u>		<u>La Plata Maryland</u>	<u>16 Nov 55</u>
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>11-21-55</u>	<u>St Peters Cemetery</u>	<u>Waldorf, Md</u>
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
<u>11/21/55</u>	<u>Julia H. Casey</u>	<u>Hunt Funeral Home</u>	<u>Waldorf Md</u>

CERTIFICATE OF DEATH

RECEIVED
NOV 23 1951
BUREAU V

1. Name of deceased
2. Sex
3. Race
4. Date of birth
5. Place of birth
6. Date of death
7. Place of death
8. Cause of death
9. Signature of physician
10. Signature of registrar
11. Date of registration
12. Name of registrar
13. Name of informant
14. Address of informant
15. Signature of informant
16. Date of completion
17. Name of official
18. Signature of official
19. Date of filing
20. Name of filer
21. Signature of filer
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96. Signature of filer
97. Date of filing
98. Name of filer
99. Signature of filer
100. Date of filing

1

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VS-15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10751

10748 CERTIFICATE OF DEATH

Items 8,9,11: film G 189 11-28-55 L

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
CITY <i>Charles</i>		STATE <i>MARYLAND</i>		CITY <i>Charles</i>		COUNTY <i>Charles</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Port Tobacco</i>				TOWN <i>Port Tobacco</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <i>Henry Vroom DeMott</i>				4. DATE OF DEATH (Month) <i>Nov</i> (Day) <i>12</i> (Year) <i>1955</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>		8. DATE OF BIRTH <i>May 10, 1887</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday <i>68</i> Yrs. <i>64</i> Months <i>6</i> Days <i>2</i> Hours <i></i> Min. <i></i>		11. BIRTHPLACE (State or foreign country) <i>New Brunswick, N.J.</i>	
13. FATHER'S NAME <i>Jacques S. DeMott</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i> (If Yes, give war or dates of service)				14. MOTHER'S MAIDEN NAME <i>Sarah F. Cartlyou</i>		16. SOCIAL SECURITY NO.	
				17. INFORMANT & ADDRESS <i>Mrs. Elva S. DeMott</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Coronary occlusion</i>						<i>5 min</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Coronary artery - heart disease</i>						<i>1 year</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <i>8</i>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>12 Nov</i> , 19 <i>53</i> , to <i>12 Nov</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>12 Nov</i> , 19 <i>55</i> , and that death occurred at <i>5:25 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>A. Wooddy MD</i>				ADDRESS (Street, city, town, state) <i>La Plata Md.</i>		DATE SIGNED <i>14 Nov 55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>11/16/55</i>		NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>		LOCATION (City, town, or county) (State) <i>Switland Md</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Jalen H. Pusey</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Chas. T. J. J. J.</i>		ADDRESS <i>Funeral Home in La Plata</i>	
DATE <i>11/15/55</i>							

10751

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

10751 CERTIFICATE OF DEATH

Reg. No. 10751

1. Name of deceased (Print or write full name)

2. Date of death (Month, day, year)

3. Place of death (City, town, or village; street or location)

4. Cause of death (State immediately and briefly)

5. Manner of death (Natural, accident, suicide, homicide, etc.)

6. Signature of attending physician (Print name and sign)

7. Signature of registrar (Print name and sign)

8. Signature of informant (Print name and sign)

9. Signature of medical examiner (Print name and sign)

10. Signature of coroner (Print name and sign)

11. Signature of funeral director (Print name and sign)

12. Signature of undertaker (Print name and sign)

13. Signature of cemetery (Print name and sign)

14. Signature of burial place (Print name and sign)

15. Signature of interment place (Print name and sign)

16. Signature of crematorium (Print name and sign)

17. Signature of other place (Print name and sign)

18. Signature of other place (Print name and sign)

19. Signature of other place (Print name and sign)

20. Signature of other place (Print name and sign)

21. Signature of other place (Print name and sign)

22. Signature of other place (Print name and sign)

23. Signature of other place (Print name and sign)

24. Signature of other place (Print name and sign)

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

10749 CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

10752

Reg. Dist. No. 100

1. PLACE OF DEATH COUNTY <u>Charles</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Rural</u> TOWN <u>Harrod</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Charles</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Rural (Preston) Md</u> TOWN <u>Preston</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>THOMAS WILLIAM HIGDON</u>		4. DATE OF DEATH (Month) <u>11</u> (Day) <u>25</u> (Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Married</u>	8. DATE OF BIRTH <u>4-28-92</u>
10a. USUAL OCCUPATION (Give kind of work done during most of preceding year, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Md. CHAS Co.</u>
13. FATHER'S NAME <u>REV. S. A. HIGDON</u>		14. MOTHER'S MAIDEN NAME <u>SUSAN THOMPSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>World War I</u>		16. SOCIAL SECURITY NO. <u>216-10-8873</u>	
17. INFORMANT AND ADDRESS <u>CATHERINE E. HIGDON (Wife)</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause (a) <u>CORONARY OCCLUSION</u> Antecedent cause(s) (b) <u>SCHEROSIS</u> Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c) <u>GEN ART</u>		INTERVAL BETWEEN ONSET AND DEATH <u>11-25-55</u> <u>Jan 1953</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED (While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined			
SIGNATURE <u>Edelen</u>		DATE SIGNED <u>11-25-55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>		DATE THEREOF <u>11-25-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Arden Forest</u>		LOCATION (City, town, or county) (State) <u>Arden Forest Va</u>	
DATE REC'D BY LOCAL REG. <u>11-25-55</u>		24. FUNERAL DIRECTOR <u>Will Harris</u> ADDRESS <u>Washington DC</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The content is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

10750 MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

10753

Reg. Dist. No. 100

1. PLACE OF DEATH COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bryans Road</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bryans Road</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) (Middle) (Last) <u>THOMAS (Tommie) PHILLIPS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>11 20 1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>9-17-55</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday (If under 1 year) (If under 24 hrs.) yrs. <u>2</u> Months <u>3</u> Days <u>1</u> Hours <u>1</u> Min.
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jackie Lee Phillips</u>		14. MOTHER'S MAIDEN NAME <u>Anne Marie Dennison</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>795.3</u> Immediate cause (a) <u>Unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>11-20-55</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Baby found dead in bed by parents 11-20-55</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Spent to bed well</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH		PLACE (Home, farm, factory, street, or office) INJURY <u>Home</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> SIGNATURE <u>E. Hedilen</u> (Degree or title) <u>MD.</u> ADDRESS <u>Laplace Rd</u> DATE SIGNED <u>11-20-55</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>11/21/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Bumpy Oak</u>		LOCATION (City, town, or county) (State) <u>Panthers Md.</u>	
DATE REC'D BY LOCAL REG. <u>11/21/55</u>		REGISTRAR'S SIGNATURE <u>Julius H. May</u>	
24. FUNERAL DIRECTOR <u>Jackie Lee Phillips</u>		ADDRESS <u>Bryans Rd. Md.</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

10751 MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

10754

Reg. Dist. No.

1. PLACE OF DEATH— COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED— STATE <u>Maryland</u> COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Newport (near) High</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Newport (near) High</u> <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>MYRON</u> (First) <u>TIMOTHY</u> (Middle) <u>PLATER</u> (Last)		4. DATE OF DEATH <u>Nov</u> (Month) <u>7</u> (Day) <u>1955</u> (Year)	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH <u>May 1 1914</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>1</u> If under 1 year Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>
11. BIRTHPLACE (State or foreign country) <u>Charles Co, Md</u>		12. CITIZENSHIP <u>US</u>	
13. FATHER'S NAME <u>Frank Plater</u>		14. MOTHER'S MAIDEN NAME <u>Rosie Plater</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>2-2002</u>	
17. INFORMANT AND ADDRESS <u>Frank Plater, Newport, Md</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Septicemia</u>			<u>12 hrs</u>
Antecedent cause(s) (b) <u>Sore throat</u>			<u>24 hrs</u>
Disease or condition, if any, giving rise to the above cause, stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <u>7. M. Johnson</u>		DATE SIGNED <u>7 Nov 55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE <u>11-9-55</u>	
NAME OF CEMETERY OR CREMATORY <u>St Mary's cemetery</u>		LOCATION (City, town, or county) <u>Newport, Md</u>	
DATE REC'D BY LOCAL REG. <u>11-9-55</u>		24. FUNERAL DIRECTOR <u>Worth Funeral Home</u>	
REGISTRAR'S SIGNATURE <u>M. P. Howard</u>		ADDRESS <u>W. C. Co. 1117</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
10752 CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

10755

Reg. Dist. No. 100

1. PLACE OF DEATH COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Lanham</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Waldorf</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>100</u>		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print) <u>DAVID</u> (First) <u>RYON</u> (Middle) <u>POSEY</u> (Last)		4. DATE OF DEATH (Month) <u>11</u> (Day) <u>19</u> (Year) <u>55</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Single</u>	8. DATE OF BIRTH <u>July 28, 1940</u>
9. AGE last birthday <u>15</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>D.C.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Student</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>Wm. Howard</u>		14. MOTHER'S MAIDEN NAME <u>Ryan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>Ms. Audrey Moreland, Waldorf, Md.</u>	
17. INFORMANT AND ADDRESS <u>Ms. Audrey Moreland, Waldorf, Md.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>HEMORRHAGE</u>			<u>11-19-55</u>
Antecedent cause(s) (b) <u>SEVERE LEFT JUGULAR</u>			<u>11-19-55</u>
Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c) <u>AUTO ACCIDENT</u>			<u>11-19-55</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.		PLACE OF INJURY (City or town, county, state) <u>Lanham, Md.</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>11 19 55 10:30 pm.</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
HOW DID INJURY OCCUR <u>Auto accident - passenger</u>			
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> SIGNATURE <u>Dr. Helen R. D.</u> ADDRESS <u>Waldorf, Md.</u> DATE SIGNED <u>11-19-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>11/25/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		LOCATION (City, town, or county) (State) <u>Switzland, Md.</u>	
DATE REC'D BY LOCAL REG. <u>11/23/55</u>		REGISTRAR'S SIGNATURE <u>Julia H. Carey</u>	
24. FUNERAL DIRECTOR <u>Hunt & Ryan, Waldorf, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cases of death clearly and legibly.

10753

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10756
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 105

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR	
TOWN <u>Waldorf (Rural)</u>		<u>Life</u>		TOWN <u>Waldorf (Charles)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Mary Ann Roberson</u>				<u>Nov. 25, 19 55</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>Female</u>		<u>Negro</u>		<u>Single</u>		<u>Nov. 25, 1955</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday: yrs. Months Days		IF UNDER 1 YEAR IF UNDER 24 HRS. Hours Min.	
						<u>15</u>	
11. BIRTHPLACE (State or foreign country):				12. CITIZEN OF WHAT COUNTRY?			
<u>Waldorf (Rural)</u>				<u>U.S.A.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Henry Garfield Roberson</u>				<u>Martha Imogene Ford</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
				<u>Martha Imogene Ford Waldorf, Md.</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a)..... <u>Generalized deformity</u>							
DUE TO <u>dwarf like with seven fingers & paper thin abd wall</u>							
Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause DUE TO <u>add wall</u>							
stating underlying cause last (c)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:							
28. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town), (County)		(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>[Signature]</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>11-26-55</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>11-26-55</u>		NAME OF CEMETERY OR CREMATORY <u>Brown Cemetery</u>		LOCATION (City, town, or county) (State) <u>Waldorf Md</u>	
DATE REC'D BY LOCAL REG. <u>11-16-55</u>		REGISTRAR'S SIGNATURE <u>M. L. Monroe</u>		24. FUNERAL DIRECTOR <u>Hunt Funeral Home</u>		ADDRESS <u>Waldorf, Md</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
10754 CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

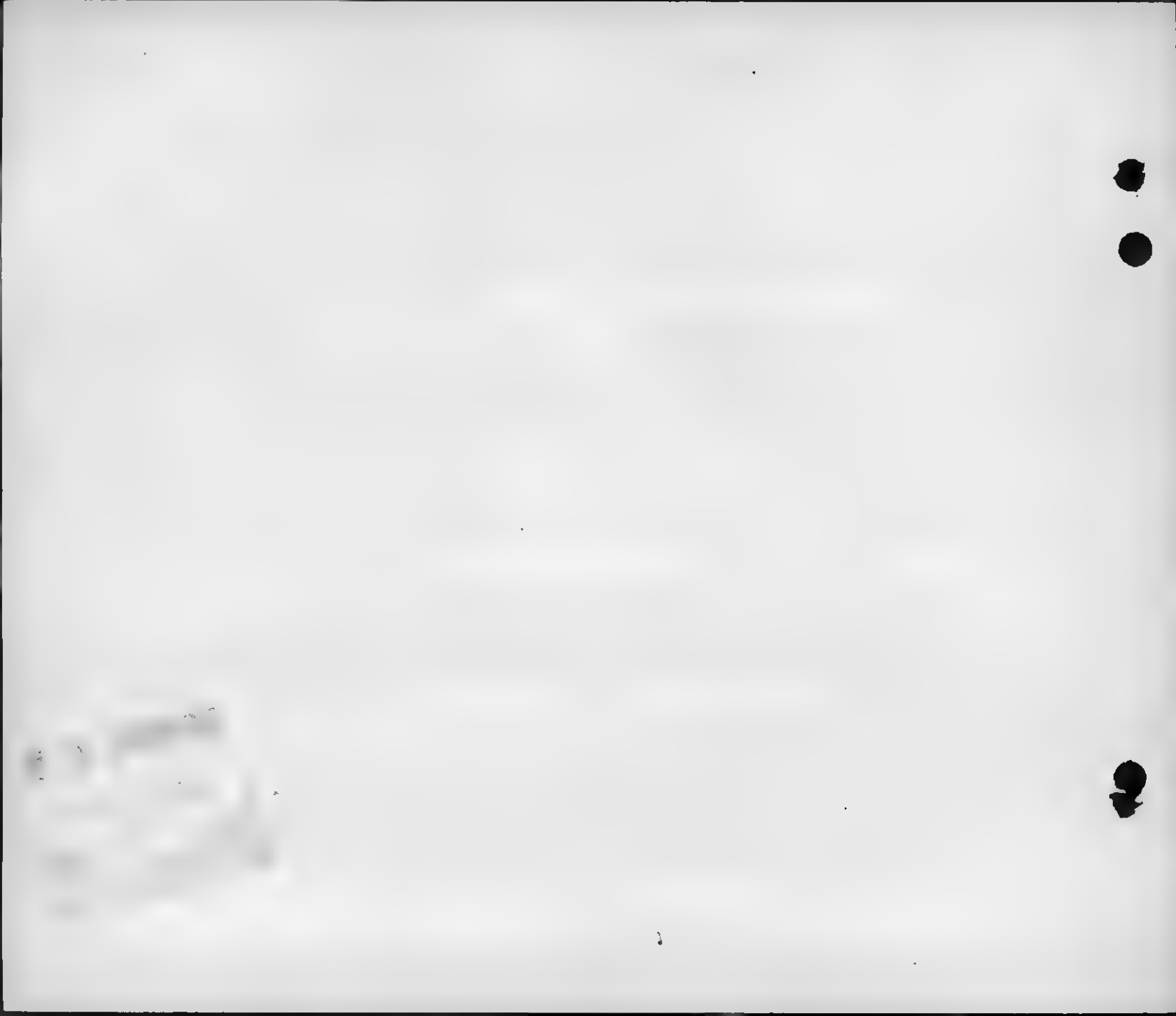
10757

Reg. Dist. No. 100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethelton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethelton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print) <u>Rodger</u> (First) <u>L</u> (Middle) <u>Rosier</u> (Last)		4. DATE OF DEATH <u>Nov</u> (Month) <u>19</u> (Day) <u>1955</u> (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Feb 2 1914</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	9. AGE (last birthday) <u>41</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Charles Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>Annie Rosier</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Army</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Harry Rosier Bethelton</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebral hemorrhage</u>			<u>11-19-55</u>
Antecedent cause(s) (b) <u>Fractures of ankle</u>			<u>11-19-55</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Pedestrian hit by auto</u>			<u>11-19-55</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> PLACE OF INJURY <u>Highway 301</u> (CITY OR TOWN) <u>Bethelton</u> (COUNTY) <u>Charles</u> (STATE) <u>Md</u>			
TIME (Month) (Day) (Year) (Hour) <u>11</u> <u>19</u> <u>55</u> <u>4:30</u> AM		INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR? <u>Pedestrian hit by auto</u>			
22. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes, accident, suicide, homicide, undetermined.			
SIGNATURE <u>R. Rodger</u> (Degree or title)		DATE SIGNED <u>11-20-55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>11-22-55</u>	
NAME OF CEMETERY OR CREMATORY <u>St Thomas Mason</u>		LOCATION (City, town, or county) <u>Bethelton</u> (State) <u>Md</u>	
DATE REC'D BY LOCAL REG. <u>11/22/55</u>		24. FUNERAL DIRECTOR <u>Wmhart Funeral Home Inc</u> ADDRESS <u>La Plata Md</u>	



CERTIFICATE OF DEATH

Reg. Dist. No. 106...

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Charles</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Charles</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Indian Head</u>	<u>6 Yrs.</u>	TOWN <u>Indian Head Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Annie Ophelia</u>	(Middle) <u>Short</u>	(Last) <u>11-4-55</u>	
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>Negro</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>		8. DATE OF BIRTH: <u>9-4-1878</u>	
9. AGE last birthday <u>77</u> yrs.		10. AGE last birthday (If under 1 year, Months Days Hours Min.)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME: <u>Fred Greer</u>		14. MOTHER'S MAIDEN NAME: <u>Eliza Chun</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Helen Carter (Granddaughter) Piggah Id.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Malnutrition</u>		One Month	
ANTECEDENT CAUSE (B) <u>General Arterio-Sclerosis</u>		Indefinite	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Senility</u>		Indefinite	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>10-23-55</u> , 19 <u>55</u> , to <u>11-4-55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11-4-55</u> , 19 <u>55</u> , and that death occurred at <u>12:15</u> M, from the causes and on the date stated above.			
SIGNATURE <u>James E. Andrews Md</u>		DATE SIGNED <u>11-4-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>11/4/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Smiths Chapel</u>		LOCATION (City, town, or county) (State) <u>Indian Head Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>11/6/55</u>		REGISTRAR'S SIGNATURE <u>Odey Price</u>	
24. FUNERAL DIRECTOR <u>John... - Jenkins</u>		ADDRESS <u>1702 12th St</u>	

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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly shall be detached for use as a burial transit permit.

VII AISC 1-5-10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10755

CERTIFICATE OF DEATH

10758

Reg. Dist. No. 100

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Charles</i>	CITY (If outside corporate limits, write RURAL and give nearest town)	STATE <i>Md</i>	COUNTY <i>Charles</i>
TOWN <i>Laurel</i>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	TOWN <i>Laurel</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Laurel Memorial Hosp.</i>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) <i>Robert James Simmons</i>		4. DATE OF DEATH (Month) <i>11</i> (Day) <i>25</i> (Year) <i>1955</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>S</i>	8. DATE OF BIRTH <i>11-25-55</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
13. FATHER'S NAME <i>James L. Hamilton</i>		14. MOTHER'S MAIDEN NAME <i>Robertine Hamilton</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <i>James L. Hamilton, 7120</i>			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		19. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <i>776x Prematurity</i>		INTERVAL BETWEEN ONSET AND DEATH <i>146 1/2 hrs</i>	
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION <i>11-20-55</i>		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)	
21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>9-10-55</i> to <i>11-25-55</i>, that I last saw the deceased alive on <i>11-20-55</i>, and that death occurred at <i>2:35</i> P.M. from the causes and on the date stated above.			
SIGNATURE <i>R. J. Edelen</i>		DATE SIGNED <i>11-25-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>buried</i>		24. REC'D BY REGISTRAR	
DATE THEREOF <i>11-27-55</i>		REGISTRAR'S SIGNATURE <i>Julia A. Barry</i>	
NAME OF CEMETERY OR CREMATORY <i>St. Jos.</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>The Heart Funeral Home</i>	
LOCATION (City, town, or county) (State) <i>Towson Md</i>		ADDRESS <i>1111</i>	

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1944

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

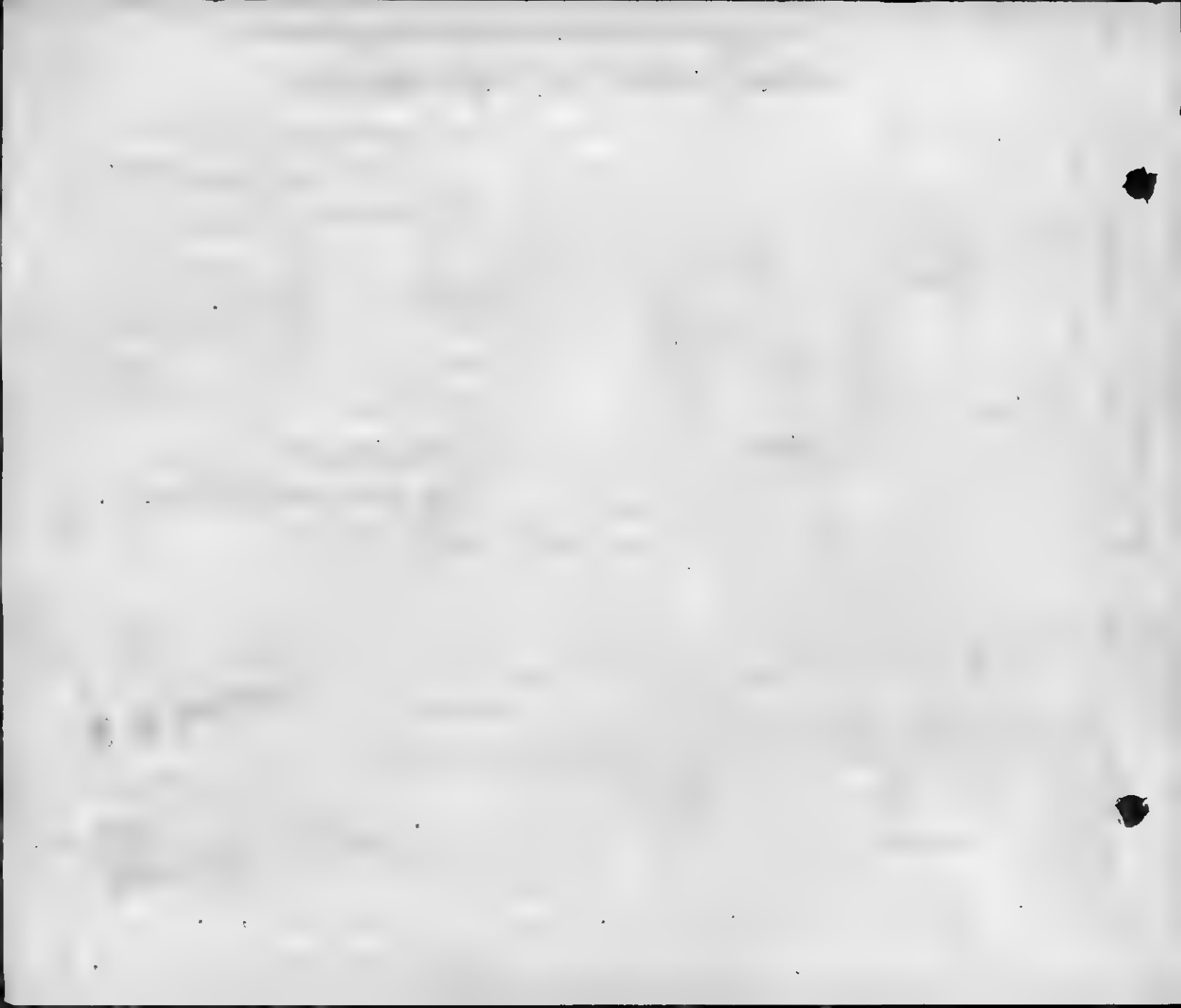
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10756 CERTIFICATE OF DEATH

11891

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Charles		MARYLAND		STATE Maryland		COUNTY Charles	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Faulkner				TOWN Faulkner			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
SHIRLEY ANN THOMAS				Nov. 10, 1955			
5. SEX	6. CO. OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
F	C	Single	8-16-55	3	3		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Infant				Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
George Hicks				Mary Alice Thomas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no				Mary Alice Thomas, Faulkner, Md.			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
Respiratory infection				1 week			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
Fractured femur at birth				all her life			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov. 4, 1955, to Nov. 10, 1955, that I last saw the deceased alive on Nov. 8, 1955, and that death occurred at 11:00 a.m. from the causes and on the date stated above.							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		11-12-55		St. Marys		Newport, Md.	
Burial							
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 12/22/55		Julia H. Parson		Archart Funeral Home, La Plata, Md.			



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INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

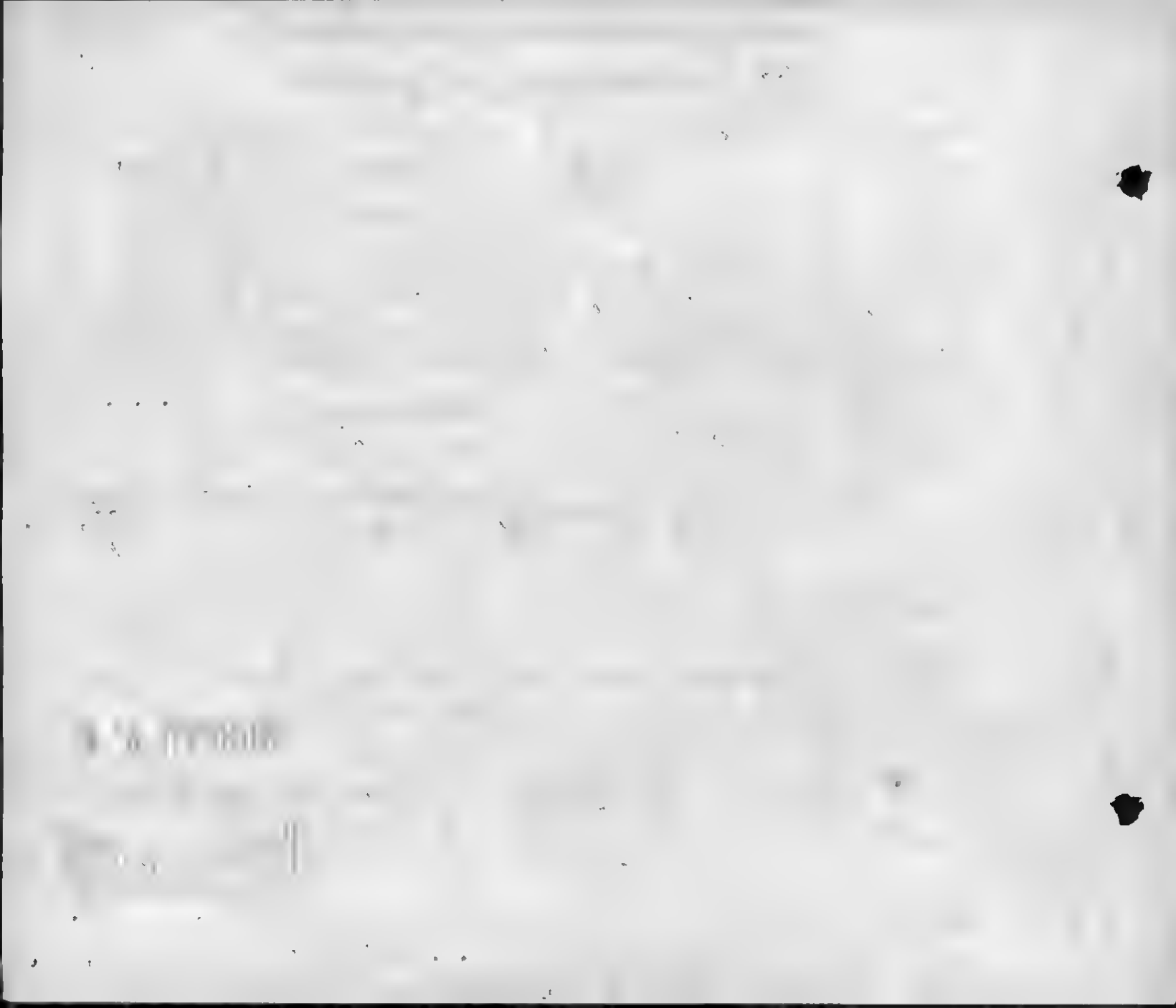
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10759

10757 CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH Lutkata		2. USUAL RESIDENCE (HOME) OF DECEASED	
CITY (if outside corporate limits, write RURAL and give nearest town) X TOWN		STATE Maryland COUNTY St Mary's	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Phys. Men. Hosp.		CITY (if outside corporate limits, write RURAL and give nearest town) Avenue 18x-2	
3. NAME OF DECEASED (Type or Print) James Oakley Tippet		4. DATE OF DEATH (Month) 11 (Day) 28 (Year) 1955	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) M.D.	8. DATE OF BIRTH 10-5-85
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	9. AGE last birthday 70 yrs.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Webster Tippet		14. MOTHER'S MAIDEN NAME Mary Handcock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT & ADDRESS Mrs Bernadette Simpson Charlotte			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 171X IMMEDIATE CAUSE (A) C.A. - PROSTATE		18. MEDICAL CERTIFICATION INTERNAL BETWEEN BIRTH AND DEATH 1952	
2. ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO (C)			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. at work Not while at work	
21e. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11-19, 1955, to 11-28, 1955, that I last saw the deceased alive on 11-28, 1955, and that death occurred at M from the causes and on the date stated above. SIGNATURE E. Edelen M.D. DATE SIGNED 11-28-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		24. REC'D BY REGISTRAR 12/1/55	
25. FUNERAL DIRECTOR'S SIGNATURE Jos. C. Mattingley		26. ADDRESS Leonardtownt, Md.	



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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-45 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10758 CERTIFICATE OF DEATH

10760

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CHARLES</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>CHARLES</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>KEECHLAND, POPES CREEK</u>		<u>40 years.</u>		TOWN <u>Rural, POPES CREEK</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<u>KEECHLAND FARM</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last) <u>WILLIAM CARLYLE TURNER</u>				(Month) (Day) (Year) <u>NOV 28 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>MALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>4-27-1891</u>	<u>64</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>BANKER</u>				<u>MARYLAND</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>ROBERT H. TURNER</u>				<u>UNKNOWN Mary Keach</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>218-14-3291</u>		<u>FRANK K. TURNER</u> <u>MD</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>CORONARY thrombosis</u>							<u>10min</u>
ANTECEDENT CAUSE(S) DUE TO (B) <u>CORONARY ARTERY DISEASE</u>							<u>4 YEARS</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>---</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>---</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<u>---</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May</u> , 19 <u>48</u> , to <u>28 Nov</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>28 Nov</u> , 19 <u>55</u> , and that death occurred at <u>12:08 PM</u> , from the causes and on the date stated above.							
SIGNATURE		M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Storwooddy</u>				<u>La Plata, Md.</u>		<u>28 Nov 55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>12/1/55</u>		<u>TRINITY</u>		<u>NEWPORT MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>12/3/55</u>		<u>Julia H. Boney</u>		<u>THE HUNTT FUNERAL HOME</u>		<u>Waldorf, Md.</u>	

CERTIFICATE OF DEATH

1. Name of deceased (Print or write full name)

2. Sex (M or F)

3. Age (Years and months)

4. Date of death

5. Time of death

6. Place of death

7. Name of physician (Print or write full name)

8. Signature of physician

BUREAU V. 2

DEC 6 1955

RECEIVED

NO. 100-100000

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS AISC 1-55 104

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10761

10759

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Charles.</i>	MARYLAND	STATE <i>MASS.</i>	COUNTY <i>58x-3</i>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <i>LaPlata.</i>	<i>36</i>	TOWN <i>NEW BEDFORD - RURAL</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural give location)		
<i>66 Physicians Memorial Hospital</i>			
3. NAME OF DECEASED (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<i>EVERETT A WHITE</i>		<i>NOV 27 1955</i>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<i>Male</i>	<i>W-white</i>	<i>Married</i>	<i>8-26-1888</i>
9. AGE last birthday		IF UNDER 1 YEAR IF UNDER 24 HRS.	
<i>67</i> yrs.		Months	Days
		Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>Engineer</i>		<i>Mechanical</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>MASS.</i>		<i>US</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Alden White</i>		<i>Anne Brown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
<i>NO</i>			
17. INFORMANT & ADDRESS			
<i>Mrs Bernice White</i>		<i>New Bedford, MASS</i>	
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		19. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A)		<i>Respiratory failure</i>	
ANTECEDENT CAUSE(S) DUE TO (B)		<i>Cerebral vascular accident</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
21a. DATE OF OPERATION		21b. MAJOR FINDINGS OF OPERATION	
21c. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21d. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21e. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21f. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21g. INJURY OCCURRED While at work Not while at work	
21h. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>26 Nov 1955</i> to <i>27 Nov 1955</i> , that I last saw the deceased alive on <i>27 Nov 1955</i> , and that death occurred at <i>4:35 P.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>J. Wooddy</i>		DATE SIGNED <i>27 Nov 55</i>	
ADDRESS (Street, city, town, state) <i>La Plata, Md.</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<i>Removal</i>		<i>11-28-55</i>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
		<i>NEW BEDFORD, MASS</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE	
DATE <i>11/28/55</i>		<i>Julia H. Boney</i>	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>The Hunt Funeral Home</i>		<i>Walden, Md.</i>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

10701

Name: *Everett A*
 Race: *White*
 Date of Birth: *March 8-22-1888*
 Sex: *Male*
 Occupation: *Engineer*
 Cause of Death: *Heart Disease*
 Date of Death: *Nov 27 1923*
 Place of Death: *Home*
 Signature: *Wm. B. ...*
 Date: *Nov 30 1923*

RECEIVED
 NOV 30 1923
 BUREAU V. S.

Recorded